The Specialist is responsible for responding to the referral of the Primary Care Physician when referrals are required for specialist intervention.

The Specialists is responsible for actively cooperating with MIHS-HP to meet the standard levels of care as prescribed by regulatory and surveying agencies, such as AHCCCS, HFCA, NCQA and the Joint Commission. Areas MIHS-HP will measure for compliance include but are not limited to medical records keeping practices, appointment availability as well environment, safety, and competencies of staff. MIHS-HP further defines the responsibilities of its Specialists as follows:

- Maintaining a health record for each MIHS-HP member assigned, taking into account professional standards, as well as appropriate and confidential exchange of information among provider network components. MIHS-HP providers must safeguard the privacy of information that identifies a particular member. Information may be released to authorized persons only. In the case of a new MSO (Managed Services Organization) or SPECIALISTS selection, medical records must be forwarded to the new SPECIALISTS or MSO as soon as possible. Original medical records must only be released in accordance with Federal or State laws, court orders or subpoenas. Records must be maintained in an accurate and timely manner. Information regarding advance directives must be kept in a prominent place in the member's file. Clear and concise communication with the member in language that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must all be documented in the member's file. ***The practice must have a process in place to arrange for interpretive services if necessary.*** Members and Providers must have timely access to records. Medical records must be maintained for at least six (6) years.

- Communicating to the member regarding specific health care needs that require follow-up and training. MIHS-HP expects that Providers will communicate with its members in a timely fashion regarding their medical care. Clear and concise communication with the member in a language and manner that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must be clearly communicated. This communication must be documented in the member's file.

- MIHS-HP expects that Providers will communicate with each other regarding the needs of it's members in a timely fashion. This includes but is not limited to diagnostic results, treatment plans, social and economic factors that may or may not impact the treating physician's ability to care for his/her patient. Test results and other outcomes should be provided to the referring physician as well as to the member as soon as possible. This communication should become a part of the patient's medical record.

- The Specialist must be available twenty-four (24) hours a day, seven days a week or arrange coverage with a MIHS-HP participating physician to provide member access during his/her absence. It is imperative that members receive care in the most appropriate setting, at the most appropriate time. Over utilization of the emergency department is strongly discouraged by the Health Plan.

- Maintain an office that is clean, safe, accessible, and supportive of member privacy and confidentiality

- The Specialist agrees to only bill members for copays, deductibles, and/or coinsurance as specified by the member's benefit coverage.

Specialists Responsibilities continued

Eligibility Verification

It is important that all MIHS-HP providers verify a member's enrollment with MIHS-HP. Presentation of a MIHS-HP and/or AHCCCS ID card is not sufficient verification of enrollment.

MIHS-HP Family Health Centers, the Comprehensive Health Center, and Maricopa Medical Center may use the Member Maintenance System to verify a member's status with MIHS-HP.

All other providers can verify a member's participation as follows:

- Contact MIHS-HP Provider Services department at 602/344-8957, Monday – Friday from 8:00a.m. to 5:00p.m. The member's ID number will be necessary to verify eligibility;

- After regular business hours, on weekends or holidays, call the Authorization Unit at 602/344-8111.

All MIHS-HP providers MUST verify membership status. Failure to do so may result in reduced or denied payments.

Copayments

Specialists may collect appropriate copayments directly from the MIHS-HP member. Providers must notify a member of copayments **before** performing the care/service. ***Providers may not refuse a member service for non-payment or inability to make the required copayment.*** Providers are free to make payment arrangements with the member as they choose, provided such arrangements follow written policies, procedures, and accepted business practices. A provider may not charge a member an additional fee for delayed or billed copayments. Providers must notify MIHS-HP Member Services if a member fails to make timely copayments. MIHS-HP will send notification to the member regarding their obligations and rights regarding overdue co-payments.

Appointment Standards

MHP expects that its specialty network will be able to provide routine appointments to its members within thirty (30) days of request. MHP routinely measures compliance with its appointment standards and makes results available to the Provider community in the Provider community in the Newsletter as well as individually. Providers who do not meet the standards will be resurveyed. Continued non-compliance will result in verbal warnings, reduction on referrals and ultimately termination from the Health Plan.

Appointment Standards appear below:

Emergency Appointments	Within 24 (twenty four) hours of referral
Urgent Referrals	Within 3 (three) days of referral
Routine Referrals	Within 30 (thirty) days of referral